



**“A TEMPORARY SOLUTION TO A PERMANENT  
PROBLEM ”- how to care for individuals with self-destructive  
behaviors in open-care.**

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## Abstract

The aim of this thesis was to gain a profound understanding about self-destructive behaviors and the risk factors that may precede them and it also aims at finding useful models to care for individuals with self-destructive behaviors. The methods in this study are systematic literature review and content analysis following Elo & Kyngäs (2007). Based on the theoretical background and research question, four themes emerged: understanding self-destructive behaviors, risk factors, possible effect of the self-injury and a care and treatment model. A theoretical model of self-injury of Nock (2010) and Morse's (2001) theory of suffering was used as the theoretical background and foundation for the study.

The findings of this study outlined self-destructive behaviors as a set of abnormal behaviors that lead to self-inflicted injuries to one's own body tissue. The behaviors can be categorized into two distinct groups, namely suicidal self-injury and non-suicidal self-injury (NSSI). Non-suicidal self-injuries are carried out to get relief, to calm down, to feel alive, to seek help from others, to get attention and be noticed rather than to end life. Risk factors for self-destructive behavior can be of an intrapersonal/internal or interpersonal/external nature. The effect of self-injury can be a visible physical injury, but the individual can attain temporary calming and relief due to the release of endorphins, opiates or oxytocin. This study also describes a patient-centered model – the Tidal model – which can be useful in the caring and treatment scheme.

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Language: English Key Words: Self-destructive behavior, self-harm, self-injury, self-mutilation

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## 1: Introduction

The area of mental health nursing comprises a small portion of general nursing despite its importance in the understanding and care of patients with mental health problem. Even though the field only constitutes a small part of my studies, I wanted to carry out a more extensive study in the field. My interest grew when I carried my practice in a mental health hospital and I decided to write my final thesis in the field. The study about how to care for self-destructive patients in an open-care setting was initiated by Korsholm HVC (health center) and communicated to me by my thesis advisor. The thesis is a literature review, and will explore the theoretical basis for providing care in an open-care (primary care) environment.

Animal studies have shown the possession of an “*inborn drive for self-preservation, survival and adaptation*” (Nock, 2010, 340) behaviors. It is a known fact that humans have an inborn drive to stay alive, reproduce and create better living conditions for themselves. However, people often behave and act in a condition contrary to this drive- one such confusing behavior is the act of self-destruction ,or self-injurious, behavior which is a direct or deliberate physical damage to one’s own body. The story of people engaging in self-harming acts is not only a modern day tale but has been recorded since Biblical time. But the number of cases of self-harming behaviors have increased considerably in recent times and the number of studies made in the area have also increased remarkably (Nock, 2010, 340).

Self-destructive behaviors are a set of abnormal behaviors that lead to physical injury or damage to one’s own body. This abnormal and dangerous behavior results in physical injury or even death. Numerous studies have found that self-destructive behaviors can be expressed generally in different self-harming behaviors such as “*self-mutilation, careless premature sexual activities, smoking, drinking alcohol, using drugs, participating in violent groups, intentional injuries, and improper ways of eating. And among those self-mutilation is the most common form*” (Nock, 2010, 340-341; Fox & Hawton 2005, 6-10).

## 2: Aim and problem definition

The aim of this study is to outline a description of self-destructive behaviors and its classifications in new scientific articles. It also aims at differentiating the models which can be useful for care of self-destructive or self-injurious patients in an open-care setting.

Problem definition

1. How is self-destructive behavior described in new scientific articles?
2. Which models are suggested in providing care for self-destructive patients in new scientific articles?

Due to the range of the concept “self-destructive behaviors”, the scope of this study is limited to non-suicidal self-injurious behaviors. It focuses on mild to severe self-injuries as shown in the classification in figure 1, and specifically self-mutilation and the related physical, mental and social problems that arise from it.

This study articles from related disciplines, such as psychiatry and psychology, are used because of their relevance in describing self-destructive behaviors. Understanding the psychological back-ground of mental health patient will enable the nurse to be increasingly familiarized with patient actions and behaviors in the correct caring and treatment processes.

The term *self-destructive behavior* is used interchangeably with *self-harm*, *deliberate self-harm*, *self-injury*, *non-suicidal self-injurious behaviors* or *self-mutilation* in much literatures. In my study it can also be reflected in the same way by mainly using the term self-injury and self-harm for the purpose of clarity and to work with in my scope. Nock (2010, 341) points to an inconsistency in the use of these terms in numerous studies, which stems from the lack of a fixed term for the concept of self-destruction.

### 3: Theoretical background

The number of patients with the self-destructive behaviors has been increasing considerably since the 1980s: particularly in the developed countries (Nock, 2010, 345). There is a high rate of self-harm activities among adolescents: approximately 13% - 45% of adolescents and 4% of adults have engaged in some kind of self-injury at some time in their life time. *“The age-of-onset of self-injury is consistently reported to be between 12 and 14 years”* and the number of people engaged in self-destructive behavior has increased since the mid-1960s (Nock, 2010, 344-345). *“In the UK self-harm is one of the top five reasons for acute medical admissions for both genders accounting for more than 150,000 hospital attendance each year”* (Cook, et.al, 2004,44) and self-harm accounts for the admission of 7% of patients in Australia (McAllister, et.al, 2009,122). The rate of non-suicidal self-injury among adolescents is considerably higher than that of self-injury with suicidal intent, 15% - 21.2% and 4.0 - 10.5% respectively (Kidger,et. al,2012, 2-5). The prevalence of self-harm including self- mutilation in Europe differs from country to country, 4.1% in the Netherlands, 9.1% in Ireland, 10.4% in Belgium, 10.9% Germany, 12.5% in Norway and in Finland *“the life time prevalence of self-mutilation was reported to be 11.5%”* in 2009 (Rissanen, et.al, 2011, 577).

The expression of self-harm can differs from person to person and to some extent between males and females. Males usually use self-harm methods such as substance abuse to minimize and suppress their painful feelings. Males who have been sexually abused at childhood have a high tendency of alcohol, marijuana and substance use before age of 10. Abused males may also engage in some form of self-destructive behaviors such as self-mutilation or suicide. Sexually abused boys have a 1.4 to 1.5 times higher rate of attempting suicide than non-abused ones (Valente, 2005, 12).

The theoretical background is the basis for understanding and explaining this study. For this purpose, I choose Nock’s model as a theoretical framework, because of its clear description of the concept, and its systematic categorization and classification into different sub-classes of self-destructive behavior. In addition the theory of suffering is included in this study to reflect on the holistic image of the stages a person goes through in self-harming behaviors.

The theoretical foundation will explain in detail what self-destructive behavior is and explore the mental, physical and social aspects of it. The nursing theory part outlines the

nursing theory of suffering and provides explanations for the stages that a person with different health problems, such as mental health problem, passes through.

### 3.1 Theoretical framework

Nock's psychological model was chosen as a theoretical framework, in order to outline the description and classification of self-injury. The model also describes the risk, vulnerability factors and the stress responses.

Self-destructive behaviors are a set of abnormal behaviors in which individuals express to cause themselves harm. Nock classified self-injurious thoughts and behaviors into suicidal and non-suicidal. Suicidal self-injurious behavior is a self-injurious behavior or action with the intent to die from the act. People engaging in non-suicidal behavior have no intention of ending their life and non-suicidal behavior includes suicidal treat/gestures, thoughts of self-injury, and mild to severe self-injury. The suicidal behavior of self-injury can be further categorized into suicide idea, suicide plan and suicide attempt as demonstrated in figure 1. (Nock, 2010, 341)

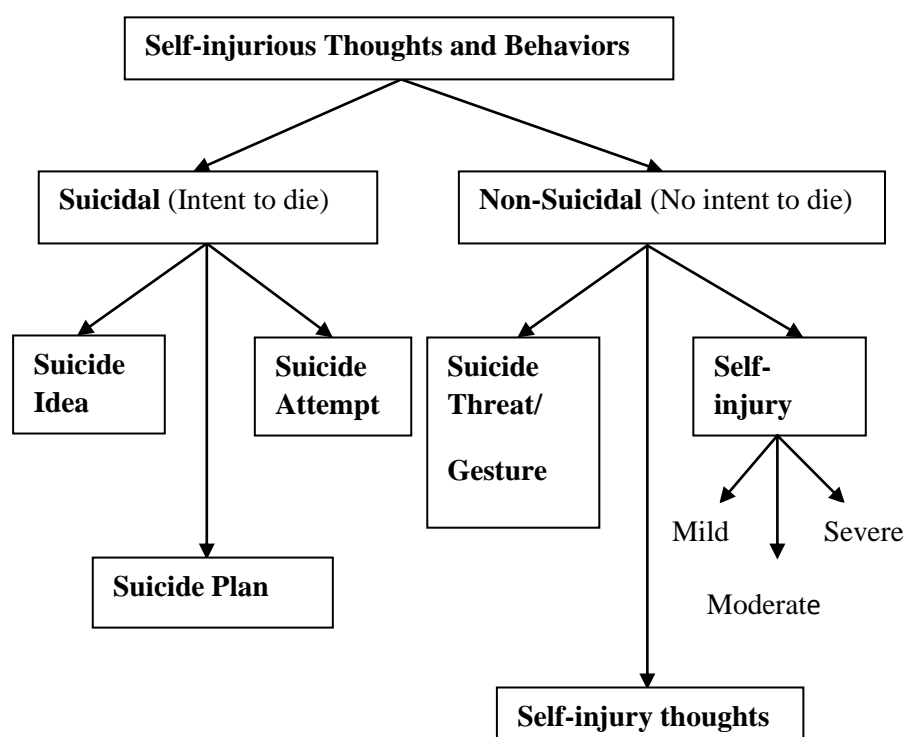


Figure 1. Classification of self-injurious thoughts and behaviors. (Nock 2010.341)

Self-harm is performed as a result of problem related to “past abuse, problem with sex or death, in regard to expressing self to others or to protect others from one’s own anger or



*rage or desire to manipulate others*” (Nock, 2010, 342-344). Nock’s theoretical model is important here because it explains the psychological and social aspects that can cause for self-destructive behaviors and it can also provide insights about the internal and external risk and vulnerability factors, and the possible stress responses. Even though it is not a nursing model, it is a basis for understanding the motives and urges of patients with self-destructive behaviors, and it explains the individual and social challenges of such problems. Understanding patients’ self-harming activities will also help health care providers construct better care plans for each patient.

Nock’s integrated theoretical model of the development and maintenance of self-injury (2010, 348) describe the major causes that lead to self-injuring behaviors in his theory as *“genetic predisposition for high emotional cognitive reactivity, childhood abuse and mistreatments, family hostility and criticism”* (Nock, 2010, 347) and makes three propositions:

1. Self-injury is repeatedly performed to function as a rapid effective way of regulating *“a person’s affective/cognitive experiences and/or to influencing one’s social environment in a desired way”*.
2. Problems controlling one’s *“affective/cognitive state or influencing the surrounding social environment (e.g., poor response to stressful events, poor verbal and social skills)”* increase the risk of self-injury.
3. The risk of self-injury is also increased by many self-injury specific factors which enable the individual to choose self-injurious behaviors rather than other maladaptive behaviors. (Nock, 2010, 347-348)

A functional approach is a behavioral psychology approach which made *“major advances in understanding, assessment, and treatment of a wide range of mental disorder and clinical behavior problems”* (Nock, 2010, 349) and this approach *“proposes that behaviors are caused by the events that immediately precede and follow them”* (Nock, 2010, 349). This approach considers self-injury to be maintained through four possible reinforcement processes. The first is intrapersonal negative reinforcement which is when the behavior is succeeded by an instant reduction of aversive thoughts or feelings such as *“tension relief or decrease in feelings of anger”* (Nock, 2010, 349). The second factor which is called intrapersonal positive reinforcement is when the behavior is followed by positive or desired thoughts or feelings which happen afterwards, these may include *“self-mutilation*

*and/or getting satisfaction from punishing oneself*” (Nock, 2010, 349). On the other hand, self-injury can be maintained by a third factor called interpersonal positive reinforcement which refers to the behavior potentially being followed by the “*occurrence or increase in social events such as attention or support*” (Nock, 2010, 349). The last reinforcement process consists of negative reinforcement, where the behavior is followed a decrease or stopping of social events such as “*peers stop bullying or parents stop fighting*” (Nock, 2010, 349). The above functional model of self-injury can be a good tool for exploring and understanding aspects of self-injurious behaviors from an internal and external point of view.

Nock’s (2010,348) integrated theoretical model of the development and maintenance of self-injury describes possible distal risk factors, such as a genetic tendency towards high emotional reactivity, childhood abuse or maltreatments and family problems. It also describes internal vulnerability and risk factors, such as emotional and cognitive aversion and poor stress tolerance, as well as interpersonal factors, such as problems in communication and problem-solving.

The model also outlines the NSSI-specific vulnerability factors which precede the actual self-injury acts. The first factor is *social learning*: this hypothesis supposes that people’s decision to engage in some form of self-injurious acts is largely influenced by what they have observed from others. The second hypothetical factor in this model is *self-punishment* which states that people may use self-harm as a way of self-punishment for what they think they did wrong, due to self-hatred or disapproval of self-image. The third factor is *social signaling* which considers the interpersonal function of self-injury: people who self-harm use self-injury as a better and more effective means of expressing their distress or to communicate with other than the usual form of communication, such as speaking, yelling, or crying. The fourth factor is the *pragmatic hypothesis* which assumes that people find self-injury to be a practical, simple, rapid, and effective way to regulate their emotions- this especially applies to young adolescents, as they lack the stress coping skills. The fifth factor is the *pain analgesia/opiate* which outlines how self-injurers have a low sensitivity to pain, caused by the presence of a high level of endogenous opiates (endorphins) in the self-injurer’s body following some form of physical self-injury. The release of endorphins reduces the feeling of pain and can result in euphoria. The last factor is *implicit identification/attitude*, it describes attitudinal tendencies of people who are troubled: they generally tend to choose the behavior that has previously given them relief in some way.

The same thing happens in self-injurers: Self-injury is used as a means of emotional/cognitive or social regulation (Nock, 2010, 351-356).

Figure 2 shows Nock's integrated theoretical model of the development and maintenance of self-injury. This figure illustrated the relationship between different risk factors; specific factors that can happen before and after the actual occurrence of self-injury, and the whole emotional and social regulation process.

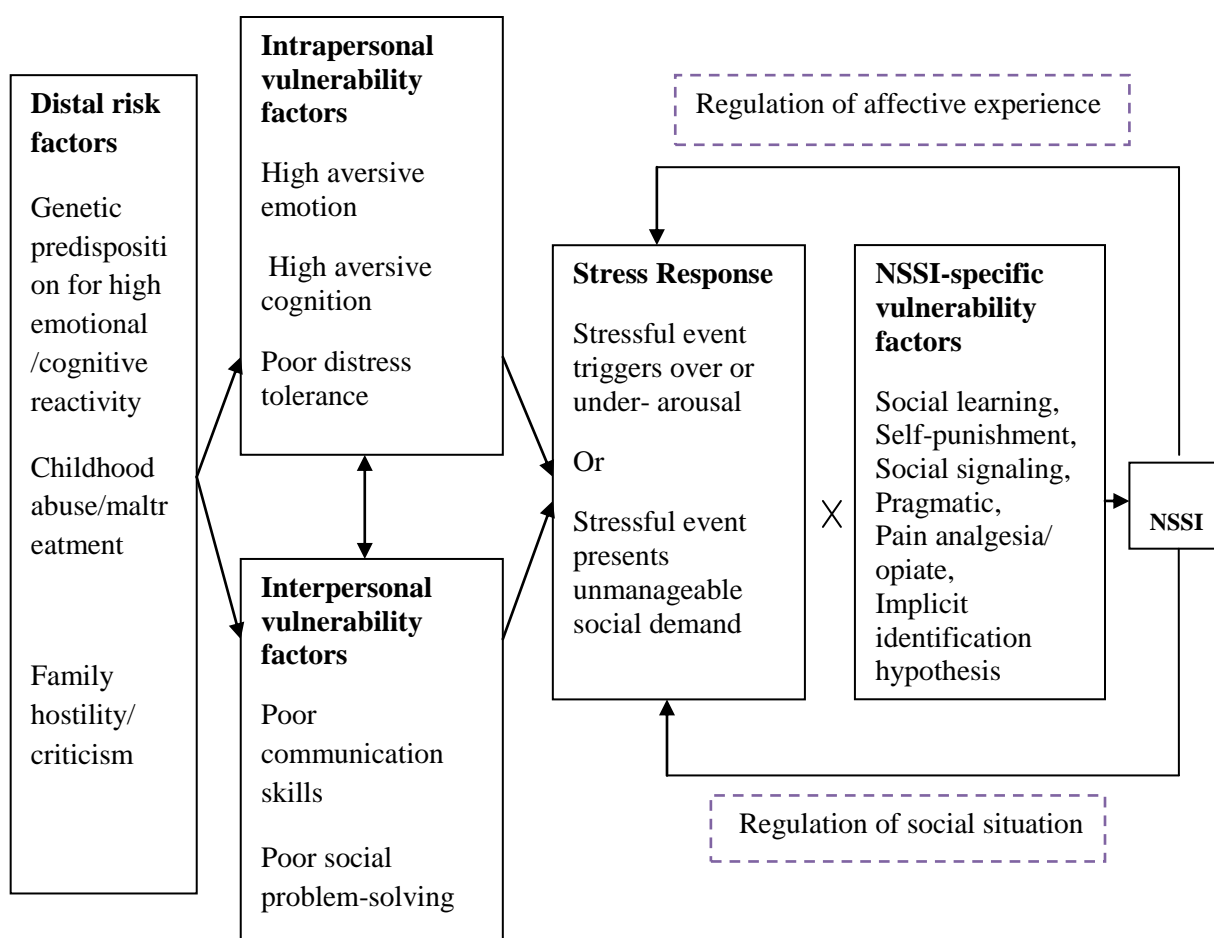


Figure 2. Integrated theoretical model of the development and maintenance of self-injury (Nock, 2010, 348)

### 3.2 Nursing theories of suffering

Most individuals who engage in self-destructive behaviors use the behavior as a coping strategy to get immediate relief from emotional suffering or distress (Selekman, 2010, 52) it is very important to understand Suffering, its different stages and the adherent behaviors of those stages. Morse (2001) developed theory suffering that can help to understand the states an individual go through while mentally distressed.

Self-destructive or self-harm behaviors can be motivated by one's suffering or emotional distress as they can result in an immediate relief of emotional distress. According to Morse, suffering can have two behavioral states namely, enduring and emotional suffering, which have distinct behavioral expressions in each state. Following Morse's theory of suffering will widen our understanding of self-destructive behaviors and activities from the perspective of nursing care and behavioral factors.

As defined in the introduction part, self-destructive behaviors are a set of abnormal behaviors which are acted out by an individual to cause harm on self. Morse defined suffering as a behavioral/emotional pain response, and that the pain can be physical or can result in an emotional response. Suffering happens when a person's physical or emotional well-being is destroyed/obstructed, and it continues until the threat of destruction/obstruction is over, or until the well-being and it will continue until the treats of destruction are over or the well-being of the person is restored (Butts & Rich, 2011, 570-576).

Morse viewed suffering as a response to bad experiences and losses in life that can affect a person's emotional wellbeing. These bad experiences can stem from loss of health or dignity, accidents that can impair a person ability to function, loss of hope or loss of beloved ones.(Morse, 2001,50-51). In caring science suffering, mainly refers to physical pain but Morse explores other dimensions of suffering. Morse views not only the patient as a person but also includes the family and the nurses' responses in giving care.

According to Morse's the praxis theory of suffering (Morse, 2001, 50-52; Butts & Rich, 2011, 570-576), suffering include two main behavioral states

## 1. Enduring

Enduring is a state when emotions are suppressed and the patient focus on the “*present and immediate threats or loss*” (Butts & Rich, 2011, 570-576). This can be expressed on the patient as a shock or disbelief and will pass as a form of suppressed emotions. Enduring is a mechanism that allow the person to pass through a particularly hard physical or emotional stress (Butts & Rich, 2011, 570-576).

According to Morse (2001, 50), “*a person of enduring in its most extreme form can show no emotion, is emotionless*”. The person can have a rigid posturing and walking way with no facial expressions and little movement of the mouth and lips while speaking. A person who is enduring give much attention to the present and blocks out the past and the future and this action will make him/her go forward on a day-to-day basis (Morse, 2001, 50; Butts & Rich, 2011, 570-576).

## 2. Emotional suffering

This is the state the patient release the suppressed emotions related to what happened to them such as injury, illness or loss. These two states are linked and “*a patient can swing back and forth in the two states of enduring and emotional suffering*” ( Morse, 2001, 51). This is a stage of emotional outburst from the enduring stage of emotional suppression expressed as being emotional, expressing anger and disappointment. The person in this state can be seen very sad, crying, sobbing and moaning or weeping constantly. At this stage the individual talk and tell their story to whomever they found repeating the story over and over. The emotionally suffering person looks stooped, fragile and has drooping facial expression. These actions or behaviors will let the person out of (escape from) the enduring “emotionally suppressed” state. (Morse, 2001, 51; Butts & Rich, 2011, 570-576)

At the end when the person has “suffered enough” hope will gradually comes to her or his mind and alternative future start to be visualized. “*It is the work of hope that brings the person from despair to the formulated self. Once suffering has been worked through people report that they revalue their lives; they live life more deeply*” (Morse 2001, 52)

Morse described that suffering can be the emotional response to different kinds of loss and also passing through an enduring stage (Butts & Rich, 2011, 570-576).

### **3.3 Reflections on the theoretical frameworks**

Morse described in her Praxis theory of suffering that a better understanding of suffering will increase the confidence of nurses in responding to the patients and families (Butts & Rich, 2011, 570-576). In my personal opinion I believe that severe mental, personal or social problem involve suffering at some stage in or throughout the duration of the problem and individuals with self-destructive problems are a good examples. Such individuals going through different kinds personal, social or psychological problems that let the individual in a distressful situation, this is also described by Nock (2010) and Arkins et.al (2013) and later the individual may perform some form of self-harm to get away from the internally accumulated emotional distress (Mangnall,et.al,2008,179; Butts & Rich, 2011, 570-576).

Nock's integrated theoretical model of the development and maintenance of self-injury and Morse's theory of suffering are the two theoretical backgrounds for this study. Nock's model and classification of self-injury is the basis for understanding the classification and description of self-injury and it also elaborates the risk factors, vulnerability factors and the stress responses (Nock, 2010, 351-356). The reason I included Morse's theory of suffering as a theoretical back ground is because I wanted to investigate a person suffering from different kinds of social or mental problem such as depression and possibly self-destructive behaviors can be manifested in Morse's state of enduring or emotional suffering states. I believe Nock's model also express a distressed person's stage of NSSI as an outburst from their enduring state of emotional suppressed and committing a break out act of physical injury which result from emotional calmness to gaining social attention. (Butts & Rich, 2011, 570-576; Nock, 2010, 351-356)

## 4: Self-destructive behaviors in primary care

Mental health problems such as self-destructive behaviors have been a challenge for primary care providers who encounter patients with such problems in a setting such as emergency rooms and other primary health care centers (McAllister, et.al, 2009, 121-122). In this chapter two major areas are viewed to review past trend of primary health care and the nurse's role, and care and intervention towards self-destructive patients.

### 4.1 Self-destructive behaviors in the primary health care and the nurse's role

When a self-injurer goes to healthcare facilities to seek help most healthcare centers happen to have problem giving proper handling of such patients having a tendency of following a biomedical treatment context to help these patients. Studies showed that nurses in an emergency setting may believe patients with self-harm injury need the same care as any other emergency case. According to McAllister, et.al (2009, 121) trying to give care or treatment in a biomedical treatment context may not be the correct context. And it also stated that emergency nurses' accuracy in assessing patients with mental health cases is much lower compared to their assessing accuracy of medical cases which is high. In the same study done to assess the emergency nurses' competence towards handling mental health cases, it has been found that emergency nurses may *"lack necessary knowledge, understanding and communication skills to provide appropriate treatments"* for patients with self-harm injuries (McAllister, et.al, 2009, 121-122).

The rising number of self-harm patients coming to emergency units brought a challenge to emergency nurses. The lack of knowledge and training to help self-harm patients can cause a major gap in quality service giving by health care centers and emergency nurses as the first professional facing the self harm patients are expected to show *"more caring behaviors and be less judgmental"* (McAllister, et.al, 2009, 122)

Studies found out also that the lack of knowledge and understanding of nurses particularly of emergency nurses who are in the front line of care giving caused negative view of patients with self-harm injuries followed by giving low priority. Nurses may have negative attitude toward patient with self-harm in some cases *"considering such patients as*

*troublesome or attention seeking and showed unfavorable attitude towards these patients*". This is caused by the lack of knowledge and understanding of nurses about why patients harm themselves. The negative attitude towards patients who self-harm is because of the nurses' misconception of associating self-harm and injury, and "*encountering and coping with the suicide of a patient on the ward*" (McCann, et.al, 2005, 1705)

When we see the view of self-harm patients in acute psychiatric patients it is noted that better understanding is there but psychiatric nurses may feel less equipped when it comes to treating the physical injuries.(McCann,et.al,2005,1705) However there is a considerable amount of self-harm cases happen in acute psychiatric ward. A study of 522 inpatients in a psychiatric ward in London and surrounding areas showed an "*11% self-harmed, 4% attempted suicide and 2.5% of them had both self-harmed and attempted suicide*" (Stewart, et.al, 2011, 1005-1006)

## **4.2 Care and intervention**

Care for self-harming patients need a deep understanding and knowledge of self-destructive behavior causes and reasons and it also need to consider the psychological and physical care need of the patients. Better understanding of why patients perform a self-harm and positive attitude towards patients can result in a quality care. The care for a self-harming should not be only biomedical and physical instead it should also consider the mental health problems (McCann, et.al, 2005, 1705).

Different intervention strategies are mentioned in different studies to reduce self-harm and its repetitions which can be categorized under therapeutic intervention for individual patients and intervention which focus on improving the service provision or resource allocation (Cook, et.al, 2004, 48).

According to Cook, et.al (2004, 48) "*the choice of therapeutic intervention should be based on the results of a comprehensive psychosocial assessment*". Studies showed that 30-40 per cent of the patients who went to hospital for general services following self-harming incidents have a diagnosable mental illness and around one-third had visited a mental health services. In those kinds of cases self-harming may be directly related with mental conditions such as depression although many of the self-harming patients do not have a diagnosable mental illness. Instead of relating self-harming behaviors with mental illness



most of the patients associate their behaviors with social problems. The selection of interventions mechanism for such kind of patients should consider the different motivational factors for their self-harming behaviors. Evidences that can support the selections of intervention for specific patient case is limited and many of the studies have fundamental methodological defect (Cook, et.al 2004, 48-49).

## **5: Methodology**

This section contains and describes in detail how the study is conducted and the methods used in this study. Detailed description of the systematic review and deductive qualitative content analysis methods of carrying out research is main purpose of this section.

### **5.1 Systematic Review**

A systematic review is a study that systematically collects research evidence about a certain research question by “*carefully developed sampling and data collection procedure*”. The methodological procedure used in a systematic review must be reproducible and verifiable. Data collection and sampling must be done in disciplined and transparent way to minimize subjectivity and also incorrect and misleading conclusions must be avoided. Precise combination of research evidence and systematic review are considered the foundation of evidence-based practice (Polit & Beck, 2012, 653).

Systematic review is different from literature review in the process of developing, testing, and committing to a certain protocol in acquiring data or acquiring the research evidence from a previous study that has been made to address a particular question (Polit & Beck, 2012, 653).

Systematic review is a precise synthesis of research findings which can be used in quantitative or qualitative studies. When it uses evidence from quantitative studies the technique is called meta-analytic technique, where the reviewers combine the evidence based on a common metric. Systematic review of evidence from qualitative studies can be found in many terms such as metastudy, metamethod, qualitative meta-analysis and the like but the common term for this technique in nurse researchers is metasynthesis.(Polit & Beck, 2012, 654)

## 5.2 Content Analysis

Content analysis has been defined by Polit and Beck (2012, 723) as “*the process of organizing and integrating materials from documents, often narrative information from a qualitative study, according to key concepts and themes*”. Whereas Elo and Kyngäs (2007, 107) defined content analysis as “*a method of analyzing written, verbal or visual communication messages*”. A definition of different perspective has been given by Hsieh and Shannon (2005, 1277) describing content analysis as “*a family of analytic approaches ranging from impressionistic, intuitive, interpretive analyses to systematic, strict textual analyses*”. Content analysis has also been described as a systematic and objective method of research, a method of analyzing documents, a method of filtering documents in to fewer content related categories, words or phrases that fall in to similar sense of meanings.(Elo & Kyngäs,2007,108).

Content analysis is a systematic and objective research method to describe phenomena, it aims to gain a deeper and wider description of phenomenon and as an outcome it expects to get concepts or categories that describe the phenomenon. The purposes of those concepts or categories are to construct a model, conceptual system or conceptual map (Elo Kyngäs, 2007, 108). In this particular study the purpose of the content analysis is to get detailed description and to identify the classification of self-destructive behaviors based on the Nock’s and Morse’s theoretical foundation and look for models of care and treatment in new scientific articles.

Content analysis has been used widely in health studies in recent years and the number of studies using this method have increased rapidly after 1990s (Hsieh & Shannon, 2005, 1277). According to Elo and Kyngäs (2007, 108) content analysis has been used in nursing in the areas of psychiatry, gerontology and public health studies. Although it has been used widely in different fields it did not escape from some criticism such as lack of detailed statistical analysis while used in qualitative study and as being not sufficiently qualitative in nature. Despite those downsides content analysis has also been praised for the benefits it offers in nursing researches. Some of benefits it offers are flexible research design, as being a content-sensitive method and gives the result as a simple descriptive data (Elo & Kyngäs, 2007, 108-109).

As described by Elo and Kyngäs (2007) content analysis is content-sensitive and the approaches to carry out the process depend on the purpose of the study. Depending on that

content analysis can be used by either qualitative or quantitative data following either inductive or deductive approach. The inductive approach is used when former knowledge about a specific phenomenon is limited or the knowledge is disorganized. Whereas deductive content analysis is used when the study bases its structural analysis on a previous knowledge. Inductive and deductive approaches differ in their data exploration. Inductive approach moves from specific to general, observing particular instances and combining them in to a larger whole or general statement. A deductive approach moves from general to the specific because it is based on previous theory or model (Elo Kyngäs, 2007,109).

The process of content analysis (Figure 3) either with inductive or deductive approaches has three phases: preparation, organizing and reporting. Although the process of content analysis is categorized in different phases there are no rules for analyzing data and the key features of all content analysis is that the text with its several words are grouped in to smaller content categories (Elo & Kyngäs,2007,109).

The preparation phase of the content analysis starts with selecting the unit of analysis. Polit and Beck (2012, 745) defined unit of analysis as “*the basic unit of focus of a researcher’s analysis-typically individual study participants*”. Deciding on what to analyze in what detail and selecting a good representative data of the whole are important considerations before selecting unit of analysis. A unit of analysis can be as narrow as a letter or a word, depending on the research question an appropriate unit of analysis should be selected. In this particular study unit of analysis is a collection of relevant words, sentences or paragraph in an article that can be related to the same meaning. Based on those units of analysis I collected sentences or portion of pages that discuss about one of the unit of analysis.

In this study content of analysis is guided by the aim and research question of the study and visible content is used for analysis. The next step after selecting the unit of analysis is done by reading the analysis units until they form a whole and an understandable meaning is gained.

The organizing phase is the next phase of the analysis process. This study follows the deductive approach of content analysis since the aim, problem definitions and searched meanings are guided by Nock’s and Morse’s theories. Through the deductive approach of the organizing phase includes developing categorization matrix, data coding according to the categories, and hypothesis testing, correspondence comparison to earlier studies etc (Figure 3). The first step in the organizing phase is developing categorization matrix which

is a process of converting data to smaller and more manageable units. The categories matrix may focus on differentiating different types of actions or events or different phases. The next step is data coding according to the categories, “*Data coding is the process of identifying and indexing recurring words, themes, concepts within the data*” (Polit & Beck ,2012).The last step in the organizing phase includes a series of actions: hypothesis testing, correspondence comparison to earlier studies etc( Elo and Kyngäs, 2007,109-111; Polit & Beck ,2012,722 ).

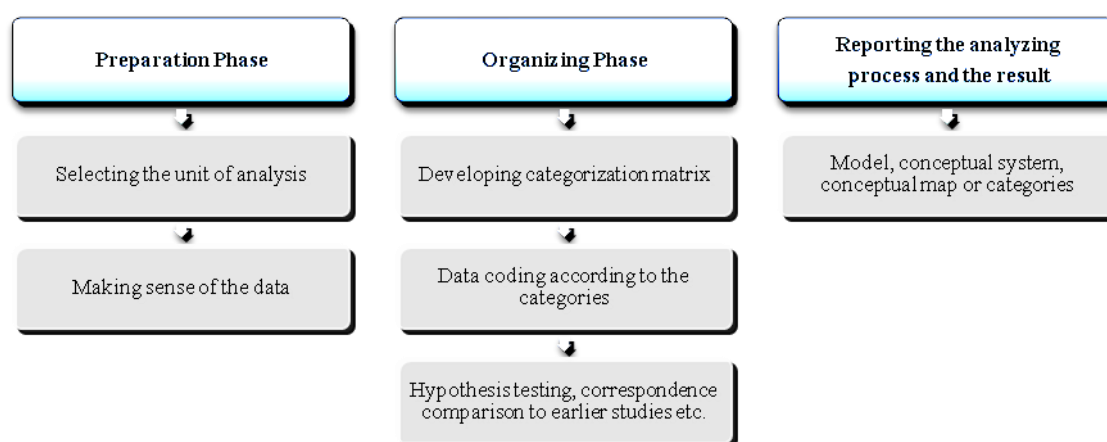


Figure 3. The process of content analysis with deductive approach (Elo & Kyngäs, 2007, 110).

The analysis process should be described clearly to the readers from the beginning until the end-result pointing out the strength and limitation. This description of the analysis process should also show how the analysis was carried out part-by-part and clarify validity of results. The results of the analysis describe the content of the categories in other words the meaning of the categories.

## **6: The study process**

The process of the study which is described in this chapter were carried out by setting criteria for collection of data, collecting the data and analyzing the data using the qualitative content analysis method.

### **6.1 Data collection**

This study is conducted using qualitative content analysis with deductive content analysis approach. Academic Search Elite Database (EBSCO) and ebrary accessed through Novia University of Applied Sciences web site and Google scholar were used to collect the different scientific article used as data source in this study.

Using the following he inclusion criteria relevant new scientific articles were selected.

1. A literature that is written in the past ten years, or written after the year 2004, with the exception of Morse's 2001 article; "Toward a praxis theory of suffering" and McAllister et.al, 2002 which I found are very important to this study but only used in the previous study section for high relevance.
2. Those articles which mainly focus on self-destructive/self-harm/self-injury/self-mutilation behaviors from mental health, mental health nursing, Psychiatry nursing, nursing care, and/or health care perspectives.
3. Studies made in English.
4. Articles which are empirical.

Article which are not written based on nursing science or caring science, non-clinical psychiatric or psychological nature are excluded and not used unless and otherwise they are included for basic definition and explanation of different concepts in terms of the relevance of correlation with each discipline. The article written by Nock (2010) is one example for this, though it is not a nursing or caring science article, in the article Nock explain and give a clear view of what self destructive behavior mean and developed a model that explain and categorize self-injury.

The literature review and study of previous research are divided into two sub-topics in order to explore how self-destructive behaviors are viewed in primary health care, the nurses' view, and the care and interventions.

The title or key word of this study which is self-destructive behavior is also used in different similar terms: self-destructive behavior, self-harm or deliberate self-harm, self-injury, self-injurious behaviors or self-mutilation. Those key words also in pair with nursing model, caring model, suffering or nursing care were used in the searching scheme. Articles were collected based on their publication time after the year 2004, articles written in English and those articles which are written on nursing and/or mental health nursing journals. Based on those and other discrete selection criteria on the EBSCO search options and a number of results were found in the beginning but 44 articles were selected on the basis of being related to the aim of the study and research questions.

A total of 32 relevant articles selected for this study and 14 of them were used in the analysis part and the rest in the literature review. The articles were selected from nursing and other related field of study journals such as advanced nursing journal, psychiatry and mental health journal, international nursing review, mental health practice journal, Nursing standards journal, journal of nursing, journal of clinical psychology and clinical psychiatry.

## 6.2 Data Analysis

Data analysis is a process of clustering related type of information about a certain phenomenon in to a logically connected scheme and it will be followed by identifying themes and categories which at the end will give us the overall description of the phenomenon. A theme is defined by Polit and Beck (2012, 562) as "*an abstract entity that brings meaning and identity to a current experience*". The purpose of the theme is to capture and unify the root basis of the experience in to a meaningful general description (Polit & Beck, 2012, 62,562).

Using Elo and Kyngäs's (2007) deductive content analysis process selected studies were analyzed accordingly. The category matrix was developed to organize the themes which were formulated based on the theoretical framework's categorical classification of self-destructive behaviors and the study questions. The themes were formulated from Nock's (2010) theoretical descriptions, based on that and the study question the category matrix

were developed and unit of analysis were identified from the articles selected for analysis. The articles selected for analysis are labeled Article 1 to Article 14 in Appendix 2 and categorized based on the themes for ease of use before unit of analysis are selected from each analysis and categorized in the category matrix. A sample view from the category matrix is presented in Appendix 1.

## 6.3 Themes

The analysis phase went through the articles selected based on their relevance to this study and four themes were emerged which are strong enough to define the concept, explain the risk factors, investigate the possible effect and find out treatment and care models of self-destructive behavior.

I. Understanding self-destructive behaviors.

II. Risk factors.

III. Possible effects after the self-injury.

IV. Care and treatment model.

### 6.3.1 Understanding self-destructive behaviors

The general behavior of self-destructive or self-injurious thoughts and actions are separated in to two distinct categories based on their intention or motive. The first category includes self-destructive behaviors which have an intention of suicide and are called *Suicidal self-injurious thoughts and behaviors* .Whereas the second category includes self-injurious thoughts and behaviors with no suicidal intentions and are called *non-suicidal self-injuries (NSSI)* which are performed for different reasons other than committing suicide (Nock, 2010,341).

#### 6.3.1.1 Suicidal self-injurious thoughts and behaviors

Suicidal self-injurious thoughts and behaviors are those actions and behaviors shown by a person who try to self harm with intent to die. A person with non-suicidal self-injury history has a higher risk of committing suicide than someone with no self-harm history

which means some form of self-harm is a risk factor for future possible suicidal attempt (Kidger et al, 2012, 2-5).

The distinction between self-harm such as self-mutilation and suicidal attempt can cause confusion but the distinctive characteristics of the two actions can be separated by the motive of the person, those who self-mutilate are thought to do so to manage stress or cope up with their stress whereas people with suicidal attempt harm themselves to end their life (McDonald, 2006, 194).

Self-mutilation and suicide are two different things, although in the 1930s self-mutilation was hypothesized to be suicidal attempt. In this regard there has been a lack of knowledge, an individual who self-harm with a suicide intent want to die whereas a person who self-harm by means of self-mutilation do it to feel better. Self-mutilators use their self-harm as a “temporary solution to a permanent problem” but they are at risk for accidental or intentional suicide (Hinck & Hicks, 2007, 409-410).

Suicidal behaviors are nearly three times higher in males than females in many western and Asian countries and the method of suicidal attempt differ among males and females, male suicide attempter used lethal suicide methods such as gas poisoning or jumping from high places whereas females used ‘low level of suicide intent and lethality’ such as drug overdose and wrist cutting. Women not only used a less lethal method of suicide attempt but the success of committing suicide is less in women than men.(Sun, et al,2005,448-449)

The most common way of suicide in many countries are hanging, suffocation, self-poisoning and drowning. Drug related poisoning is the most common method of suicide in women than any of the other methods (Sun, et al, 2005, 448).

### **6.3.1.2 Non-suicidal self-injurious thoughts and behaviors**

McDonald (2006) defines Self-mutilation as “*direct, deliberate destruction or alteration of one’s body tissue without conscious suicidal intent*”. The act of self-mutilation includes a wide range of physical self-harm acts which will not be limited to one kind, these acts include “*cutting, burning, carving, hair pulling, inserting objects under the skin, and skin picking or scratching*”, and the most common form of self mutilation in adolescents is cutting (McDonald, 2006, 193-194).



The act of self-mutilation most commonly done is in the arms, wrists, ankles and lower legs and also seldom in axilla, abdomen, inner thighs, under the breast and the genitals. The reason of selecting a specific site for self-mutilation is not known but different people do it in different part of their body with a non-suicidal intent (McDonald, 2006, 193-194).

In a study made on Finnish adolescents of age 12 to 21 years various intentions of self-mutilation have been expressed by the self-mutilators, these are (1) to feel alive, (2) to bring internal pain to an external perceivable form, to be perceived by oneself and/or by others, (3) the view of own blood from the self-mutilation can be a sign of feeling alive, (4) to attain self-control, (5) to punish oneself or someone else, (6) for experimenting, just to know how it feel, (7) a practice in Satan worship, (8) if need to have the possibility to kill oneself (9) sometimes self-mutilators can do the act for no particularly conscious purpose or intention (Rissanen, et. al, 2008, 156).

McDonald (2006) categorized self-mutilation in to two based on the reasons why it is practiced. The first one is “culturally sanctioned self-mutilation which includes rituals, traditions and practices which are practiced for different beliefs in a society”. These traditional or cultural practices can have been repeatedly performed for many generations in the society and thought to “*promote healing, spirituality and social order*”. The second category is called pathological self-mutilation which is the deliberate destruction of one’s own body with no intention of suicide. (McDonald, 2006, 194).

Pathological self-mutilation can also be categorized in to three, major, stereotypic, and moderate /superficial. Major self-mutilation is the extreme kind which causes major tissue damage but rarely happens, such as “*eye enucleating, castration and limb amputation which is associated with psychosis and acute intoxication*” (McDonald, 2006, 193-195). Stereotypic self-mutilation is a combination of similar, unvarying, repetitive and having a similar pattern which are mostly seen people with autism, Lesch-Nyhan syndrome and Tourette syndrome and individual with mental retardation. Head banging, eye gouging and self-biting are some of the common stereotypic behaviors. Moderate/superficial self-mutilation is a complex group of behaviors which result in different kinds of self-destruction of body tissue such as cutting, skin picking and hair pulling. Cutting is the most common self-mutilating method practiced by adolescents. (McDonald, 2006, 193-195).

According to McDonald (2006, 193-195) and (Starr, 2004, 34) episodic self-mutilation which is a form of moderate/superficial self-mutilation such as cutting usually is linked

with mental disorder such as bipolar disorder, borderline personality disorder (BPD), anxiety or depression.

Individuals who self-mutilate usually are unwilling and unable to ask help about their problems, they can have emotional problems, unhealthy life style such as eating disorder, nicotine or alcohol addiction or other substance abuse. In addition these individuals externally can look normal and take care of others around them but they are internally very sensitive and have a low self-esteem having a lower opinion of themselves and ashamed of their self-mutilation behaviors.( Rissanen, et al,2011,578)

Rissanen, et al (2011, 578) describe the act of self-mutilation being performed usually privately and alone and would not be told to anyone but majority of adolescents who perform the act said someone know about their self-mutilating behavior mostly their mothers.

Hinck and Hicks(2007) describe the nature of a self-mutilator's behavior as a clear urge for help from others and a source of shame that force the individual to the same action repeatedly in secret. Many self-mutilators also have negative feeling about normal thought, feelings and emotions such as sexual desire or anger, and they have a feeling of guilt and shame for experiencing such feelings and emotions. The feeling of guilt and shame will lead to self-hate and self-punishment for feelings they had (Hinck & Hicks, 2007, 410).

Even though the prevalence of self-mutilation is increasing there has been a poor understanding by health care providers, mostly a negative response towards those who self-mutilate and difficulty to treat. Patients with such problems felt that they have been stigmatized, mistreated and received poor care when they go to emergency care unit. Many health professionals and nursing staffs express their negative beliefs about those who self-mutilate as "*attention seekers*" and "*manipulators*" which shows lack of understanding of the purpose and causes of self-mutilation by the health care providers (Starr, 2004, 34).

The behavioral changes seen in individuals who self-mutilate can be noticeable enough. Self-mutilators can be seen "*wearing loose and long sleeves clothes in any weather condition to cover their wound or scars*" (Hinck & Hicks, 2007, 410). They also like to have unusual need for privacy when they change clothes. Self-mutilation occurs irrespective of gender, race, age, education or religious status but study showed that it occurs in higher rate in the white race, female gender and the adolescent age group (Hinck & Hicks, 2007, 410). The numbers of patients who commit one form of self-harming

activities are increasing mainly among young people from 15 to 24 year olds in the developed countries (Arkins et.al 2013, 28). Culhan and Taussig (2009) put youth who have been mistreated at a subgroup which is high risk for problem behaviors such as self-destructive behaviors.

According to Hinck and Hicks (2007) self-mutilators mutilate for different reasons: to escape from their feelings, to divert their internal pain to outside physical pain, to cope with certain kind of feelings, to express their anger on themselves, to feel alive, to disconnect from certain kind of emotions, to seek for help from others and manipulate situation and people (Hinck & Hicks, 2007, 411).

Hinck & Hicks (2007) describe that self-mutilation can be addictive behavior, the tissue damage during mutilation initiate the release of endorphins which causes a sense of relief for the individual. The self-mutilation usually started as a coping mechanism against anxiety, anger and other painful emotions but can remain as an addictive act to maintain a feeling of euphoria or feeling better. More and more tissue damage is required to get the relief needed and it is more difficult to stop once it has been practiced for longer period of time (Hinck & Hicks, 2007, 411).

### **6.3.2 Risk factors**

Vulnerability and risk factors that can be a cause for self-destructive behaviors can be of the person's internal problem such as mental illness, problem with sexual orientation or poor distress tolerance; such factors can be categorized under intrapersonal factors. Whereas risk factors of external nature are categorized under interpersonal factors those factors which initiated by problem with social interaction and influence and abuse by others (Gilbert, et.al, 2010, 563-564; Nock, 2010, 348).

#### **6.3.2.1 Intrapersonal risk factors**

Intrapersonal or internal treat or factors which can be a cause for behavioral problems such as self-destructive problem can be genetic factors for high emotional reactivity, emotional and cognitive problems or mental illness, poor distress tolerance (Nock, 2010, 348), self-criticism, shame and social comparison (Gilbert, et.al, 2010, 563-564)

Self-criticism is the result of an early age neglectful and abusive environment or condition threatening one by a dominant figure and creating a subordinate mentality. Negative memories of childhood can cause present time self-criticism and depression. Self-criticism is also found to be the bridge between childhood's negative experience and depression. Here what push a person to engage in self-harm are the emotional sufferings and negative feelings that follow self-criticism; emotions and feelings of anger, contempt, self-hatred and low self confidence (Gilbert, et.al, 2010, 563-566). An early age abuse and neglect of external nature can be a cause for a recent time intrapersonal problem of depression and self-criticism.

A study made by Rissanen, et.al (2008) on adolescents in Finland age 12 to 21 year identified the internal and external factors that contributed to self-mutilating behaviors. The intrapersonal or internal factors are internal conflict, loneliness, change in life style such as following heavy metal music life style, fear of violence such as fear of violent family member, experience of disease or being different and considering that as a bad or different factor to isolate self, poor self-esteem which cause a self-perception of worthlessness and try to punish self and negative emotions such as anger range and low mood.

Shame is also another internal threat that can lead to self-harm. Shame can be divided into internal shame and external shame. Internal shame is a bad image given to a person by himself or herself such as considering one own image as unattractive, inadequate or not good enough. These bad images of self can cause feeling of inferiority and defectiveness. Social comparison is a person's own estimate of his or her social rank or position in comparison to others in different attributes. Research showed that unfavorable social comparison is associated with mental health difficulties. To summarize self-criticism, shame, feelings of inferiority and submissiveness are related to self-harm (Gilbert et.al, 2010, 563-564).

### **6.3.2.2 Interpersonal risk factors**

Interpersonal or external factors such as external criticism, abuse and mistreatment (Gilbert et.al, 2010, 563-564), developmental or upbringing problems such as abuse, loss and abandonment, lack of intimacy, care and communication (Starr, 2004, 35).

Starr (2004) described the importance of internal representations of objects by children in an early age which include internal view of self as an important being in own and others

view. Children will develop sense of worthiness if they grow up receiving positive feedback about their image and importance from their parents. However individuals who have been receiving negative feedback and have been traumatized as childhood may not develop a positive sense of self. And these childhood factors can contribute to an individual's later age self-harm or self-mutilating behaviors (Starr, 2004, 36).

In a study made on Finnish adolescents Rissanen et.al (2008) identified external factors that can contribute to self-mutilation acts. The main factors expressed by the study participant self-mutilators are- being victims of violence such as rape, concrete life change of living place or condition, abuse of intoxicant and analgesics, worship of Satanism-some self-mutilators expressed the belief make them self-mutilate, and conflict and fight between family members such as parents fighting which can cause the child to self-mutilate afterwards .

The possible connection between horrifying event and the occurrence of psychological problem that comes afterward. Childhood abuse may result in self-mutilation in a reason to regulate uncontrollable emotional pain (Starr, 2004, 35).

Many studies showed self-destructive behaviors are associated with past mistreatment of people at a young age and/or current life complication in one or multiple undesired experiences such as family problem or interpersonal conflict. According to Cerdorian(2005, 42-43) self-destructive behaviors can be caused by a wide range of factors which include hopelessness, mental illness such as depression and Borderline personality disorder, problem with sexual orientation, or academic, familial, and social problems, attention seeking actions or desire to punish self or loved ones.

External shame is caused on a person by believing other people have negative view of him or her and they think and believe they have lower value in other's mind. In addition shame can be caused by an early childhood neglect, harsh parenting and physical or verbal abuse (Gilbert, et.al, 2010, 563-564).

Arkins, et.al (2013) described risk taking behaviors, substance use and interpersonal problems as common causes and associating factors that can lead to self-harming behaviors. Whereas Culhan & Taussig (2009) grouped youth who have been mistreated in the past in a subgroup which is high risk for problem behaviors such as self-destructive behaviors.

### **6.3.3 The visible effects and the hidden meaning of self-injury**

According to Hinck and Hicks (2007) self-mutilators do not find pleasure by damaging their tissue and hurting themselves but they do it to get relief, to feel better or to seek help. Individuals who self-harm can have many different reasons to engage in different self-harming acts, some of the reasons are, self-harm may bring emotional release or relief, individuals who self harm may also achieve temporary calming due to release of endorphins, opiates or oxytocin that are released in to the body following the physical injury (Gilbert, et al,2010,563).

Girls' self-harming methods are mainly cutting their arms, back of legs, and may also cut thighs, abdomen, breasts, faces, and even genitalia. They usually use needles, fingernails, razor blades, knives and burn themselves with lighters, matches, and the like. In addition they can also abuse drugs or alcohol or engage themselves in a multiple sexual relationships. There is a point that should be noted that self-harm and suicides are not the same things particularly to young women ( Cerdorian, 2005, 43).

Gilbert, et.al (2010) also describe the emotional and physiological regulation attained through self-harm for the individual in mental distress, self-harm may also be used to divert the feelings of internal pain or memories and to express out great pain or anxiety (Gilbert, et al.,2010,563).

### **6.3.4 Care and treatment model**

The treatments of people with self-harming are considered to lack insight and guidance. The number of patients who come to emergency unit is increasing in most developed countries. But there is a gap in the care giving and treatment for self-destructive patients. Studies showed that health care professionals lack the knowledge and understanding of their patients with self-destructive behaviors some even have negative attitude towards such patients. Training and increasing awareness around the nurses and other relevant

health care professionals about found to have positive impact on the treatment and handling of such patients. (McHale & Felton, 2010)

In the articles analyzed one practical model were mentioned, the model which is called patient centered model and it is selected to be included in this study. The model is not the only one noted but it is selected in this study because of its relevance, clarity and applicability to the case of self-destructive patients, due to the lack of adequate article on this subject only this model is disused in this study.

Although different models are widely mentioned in the theoretical literatures there is poor understanding in practice. According to O'Donovan (2007) patient-centered model is developed to give care based on the understanding of user need, engaging the patient in the process and maintaining well-being. It is a model of care that focuses on understanding of the parsons' outer and inner worlds from their frame of references. The patient-centered care model has components by which the model bases its care process these are; mutuality or collaboration, truthfulness or honesty and negotiations. Patient centered care model is model that can be used in multidisciplinary care areas from elderly care to mental health care (O'Donovan, 2007, 542).

There are many patient-centered models developed for different care plan some of these models are McCormack's Authentic Consciousness Model, Baker's Tidal Model, Titchen's Skilled Companionship model, Nolan's Senses framework and more models have been developed in the past and some remain at a conceptual level (O'Donovan, 2007, 543).

O'Donovan (2007) found out that even though there are many models which can be put in to practice in different nursing care areas there is a problem in adopting the model "uncritically and prematurely" because of conflict with other nurses' obligation and mental health care acts.

Tidal model is an interdisciplinary mental health model developed in recovery of people with different mental health problems. It is also considered as mid-range theory of nursing for giving mental health care. This model was developed in UK by Phil Barker and Poppy Buchanan-Barker. The model is designed to help patients with mental disorder in their recovery process by helping themselves to regain their identity, recover the meaning they had for their lives. This model puts the patient as the center of care and is designed

depending on individuals and represents the person by three domains: self, world and others. (Barker & Buchanan-Barker, 2012)

Tidal model uses its philosophical assumptions to enable the patients express themselves and to regain their personal control of their recovery and communicate better with their care givers. It also put the care giver and the patient in to commitments which both can follow in order to communicate and proceed with the individually designed recovery process. The model also has a number of competencies required by the care giver on how to help patients express out their stories, a capacity to listen to their stories, develop a care plan, develop awareness of the patients' strength and weakness and enable the patient aware of all the care plan and process. (Barker & Buchanan-Barker, 2012)

The tidal model is a model that enables the patient to be in control of the caring process and participate actively and let the nurses do only what is absolutely necessary, not creating dependencies and empowering the patients (Barker & Buchanan-Barker, 2012).

## **7: Interpretations of Results**

This study aimed at analyze scientific articles in order to answer the two research questions: How is self-destructive behavior described in new scientific nursing articles? And what models are suggested in providing care for self-destructive patients in new scientific articles? The study uses Nock's Self-injury model and Morse's theory of suffering as a theoretical framework. The study has focused on deliberate self-injurious behaviors, pointing out possible causes and effects on the patient and finding useful care and treatment models in new scientific literature.

The analysis part was written following the qualitative content analysis process of Elo and Kyngäs (2007), and the interpretation and analysis of qualitative data occurred virtually simultaneously (Polit & Beck, 2008, 576). The selected new scientific articles were studied and four themes were identified through qualitative content analysis. These themes were deemed to have the strength and descriptive capability to answer the research questions, and the articles were categorized accordingly under each theme. These four themes are *description, risk factors, effects, and care and treatment models*. The themes basically follow the core points of the theoretical backgrounds (Nock's integrated theoretical model of the development and maintenance of self-injury and Morse's theory of suffering).



Nock's integrated theoretical model of the development and maintenance of self-injury was placed in the non-suicidal self-injury sub-category based on his classification of self-injurious thoughts and behaviors (Figure 1). At this classification level the main point is to clarify the distinction between suicidal and non-suicidal self-injurious thoughts and behaviors and the distinctive point between the two behaviors is the existence of intention to die from the act of self-injury.

Suicidal self-injurious thoughts and behaviors have an obvious intention to die (Kidger, et al, 2012, McDonald,2006), whereas non suicidal ones have no intention of and clear a distinction and understanding of the two behaviors is important before any care or treatment ( McDonald,2006).

The integrated theoretical model of the development and maintenance of self-injury developed by Nock (2010) theoretically explains how self-injury stem from possible *risk factors* of genetic factor, childhood abuse and maltreatment, family hostility and criticism. Cerdorian (2005) and Gilbert, et al. (2010) described the main causes of self-destructive behaviors as childhood abuse, mistreatments, family problem, mental health problem such as BPD, social and relationship problems and problem with sexual orientation. Culhan and Taussig (2009) emphasis on youth who have been mistreated in the past having a high risk for self-destructive behaviors. The findings of this study support Nock's model in the classification, identification of risk factors and causes, the stages a self-injurer go through. All the analyzed categories fall in to Nock's model of development and attainment of self-injury.

One risk factor which is not mentioned in many articles but mentioned in Nock (2010) and Rissanen, et. al (2008) is the risk of belonging to some lifestyle or subculture such as heavy metal music life style (Rissanen, et. al, 2008, 154) and Goth subculture (Nock,2010, 347) as these may increase the engagement in self-injury.

The second set of factors in the development of self-injury in Nock's model are the *intrapersonal and interpersonal vulnerability factors* which include poor personal, emotional, distress controls and poor social problem-solving and communication skills. Gilbert et al. (2010) categorized unfavorable conditions or threats in to external and internal factors. External factors include external criticism, abuse and mistreatments, whereas internal threats are self-criticism, shame and social comparison. Rissanen et al (2011) described emotional problems and low self-esteem among the characteristics of an

individual with self-harm behavior. Starr (2004) emphasized the lack of positive self-image as one intrapersonal risk factor.

The development of a self-injury continues from the vulnerability factors to *stress response* which can lead to *NSSI-specific vulnerability factors*- Preceding factors to the actual non-suicidal self-injury (NSSI) occurs (Figure 2). NSSI-specific vulnerability factors include *self-punishment*, *social signaling* and *pain analgesia* support the themes of this study that categorized the possible effects of self-injury. Self-injury can be a tool for self-punishment as a result of self-criticism and shame (Gilbert et.al, 2010), or it can be social communication tool of seeking help from others (Hincks & Hicks, 2007) self-injury can also be performed to bring emotional release or relief and calming due to release of endorphins, opiates or oxytocin that are released in to the body following the physical injury (Gilbert, et al., 2010).

Morse's praxis theory of suffering is also used to conceptualize what a person with personal, social or psychological distress undergoes. In the first stage of suffering which is *enduring* the individual is viewed with distressful events in life that leads to depression and anxiety, which in turn cause suppression of emotion. Morse defined suffering as a response to bad experiences and losses in life that can affect a person's emotional wellbeing (Butts & Rich, 2011), and in a similar fashion, Starr (2004) described abuse, loss, lack of family intimacy and care, and abandonment as risk factors for self-injurious behavior at a later age. The second stage, *emotional suffering*, is the stage of emotional outburst, expressing anger and disappointments towards self and others (Butts & Rich, 2011).

A person who is suffering can swing back and forth between the enduring state and emotional suffering, at the enduring state of emotional suffering the person may not express his or her emotion to others but in the emotional state the individual usually want to express their feeling to someone else (Morse, 2001). A self-mutilator or self-injurer can use the act to cry out for, or seek help, from others, or as in Morse's enduring stage they may not want to have any contact with others and want to suppress their emotional suffering of guilt and shame (Hinck & Hicks, 2007). According to Morse's theory, after a long suffering episode one may regain hope and be able to find a "remodeled self" and feel better or go back to the enduring stage again. A self-injurer may pass through a similar stages: the accumulated problem inside an individual may at some point cause him or her to self-injure to feel better, gain self-control and feel alive temporarily, but the individual may repeatedly go back to the same stage of emotional crisis in the same way since self-

injury is “*a temporary solution to a permanent problem*” (Rissanen, et al, 2008; Hinck & Hicks, 2007).

Self-harming activity is also a behavioral problem that can be expressed by an individual who has been suppressing distressful emotions caused by different factors. People who self-harm can do it to escape from their feelings, to divert their internal pain, to express their anger, to disconnect from certain kind of emotions or to influence other (Hinck & Hicks, 2007). Morse’s theory of suffering is important to understand a person suffering from a condition such as depression or loss, identify the problem and find out the stage the individual is in. Even though the information gathered is limited in this study, understanding Morse’s theory of suffering can be an advance in understanding an individual suffering from any cause.

Certain care and treatment models that can be useful in self-destructive behavior cases were identified in the analyzed new articles. A patient-centered model is a care model which starts by understanding the patient’s perspective and making the care plan in full participation with the patient. This model is multidisciplinary and can be applied in different patient care fields. Different models are also designed based on the principles of the patient-centered model such as, the consciousness model, Tidal model, companionship models and Senses framework (Barker & Buchanan-Barker, 2012).

## 8: Critical review

A qualitative study should follow should follow ethical conduct and have be trustworthy, and be able to be able “*to maintain high standards of integrity and avoid such forms of research misconducts as plagiarism, fabrication of results, or falsification of data* ” (Polit & Beck, 2008, 172) and authentic citation is needed (Elo & Kyngäs, 2007, 112) is needed. This study is conducted in an ethical way of proper referencing and acknowledging the writers’ works and describing the right and correct ideas as in the original to avoid fabrication and falsification of data.

To conduct deductive qualitative content analysis, I followed the Elo and Kyngäs’s deductive qualitative content analysis way in detail through three phases of preparation, organizing and reporting phases. Trustworthiness is “*the degree of confidence qualitative researchers have in their data*” (Polit & Beck, 2008, 745) and to gain trustworthiness, “*the*

*analysis should be described in sufficient detail so that readers have a clear understanding of how the analysis was carried out” (Elo & Kyngäs, 2007, 112).*

In addition, trustworthiness includes “credibility, dependability and authenticity” (Polit & Beck, 2008, 745) and “inferences based on collection of valid and reliable data” (Elo & Kyngäs, 2007, 112). The credibility of the result shows how well the categories cover the data. To increase the reliability of the study, the result and the data should be linked by means of appendices and tables (Elo & Kyngäs, 2007, 112-114).

In this study, valid and reliable data were collected from relevant and new scientific articles and organized and analyzed in proper qualitative analysis approach. Proper content analysis requires the analysis and simplification of data and forming of categories that data and form categories that reflect the subject of study (see Elo Kyngäs, 2007, 112). Credibility is “ *criteria for evaluating integrity and quality in qualitative study*” and, in addition, “*refers to the confidence in the truth of the data and interpretation of them*” (see Polit & Beck, 2008, 725).

In this study, qualitative data was analyzed and the result is presented following a deductive approach of qualitative content analysis. The major issue in qualitative study critique is on the analytical process documentation, and the study should provide “information about the approach used to analyze the data (Polit & Beck, 2008, 576-77). I fully documented the analytical process of the whole analysis, one of the strength of my study is that I followed the process and fulfilled the analytical process. According to Polit and Beck (2008, 577) the author should also focus his/her critique on whether he/she has been faithful to one approach and the integrity of fits procedure. Throughout my study, I consistently used the deductive approach procedure of qualitative content analysis method, explaining the step by step process as the method required.

I also believed that the data analysis approach was appropriate for this study and I tried to avoid redundancy of themes, clear and descriptive themes were selected and the analytical process flow were described in the whole analysis phase of preparation, organizing and reporting. The study also identified themes that are informative and useful identify themes that are informative and useful in answering the study questions. It is also my belief that the study questions were addressed properly and discussed adequately, and that study’s focus on self-destructive behavior was effective.

Throughout the study process I have considered all the ethical aspects, been aware of credibility and trustworthiness in relation to proper use of citation, expressing the correct meaning of the author's idea, correct use of data, and correct interpretation of data. All works cited including figurative charts are properly cited and acknowledged.

Even though I made my best effort to follow the study procedures, the study has faced some difficulties from acquiring relevant new articles to interpreting and making meaning out of it to some extent because of the use of qualitative data. An additional challenge was the identification of specific and related models developed to provide care for patients with self-destructive behaviors, as there is a lack specific and related models developed to give care for patients with self-destructive behaviors because there is a lack of new scientific articles in the area. This gap shows that there is a need for future mental health nursing to explore this area and find specific and appropriate models which can be specific and relevant tools in the care and treatment process.

## **9: Conclusion**

This study was conducted to analyze new scientific articles describe self-destructive behaviors and look for models proposed to help give care for patients in an open care setting. The study focuses on non-suicidal self-injurious behaviors, such as self-mutilation, which is the most common type of self-destructive behavior. According to Nock (2010), there are at two significant reasons for carrying out a study to understand why people engage in behaviors that are destructive to themselves. The first one is that the behaviors cause major physical and psychological harm to the individuals who self-harm and can cause stress and suffering to their family and friends. The second reason is that the study can expose the real reasons for why people engage in self-harmful activities and unhealthy behaviors, including smoking and alcohol and drug abuses.

The study uses, qualitative content analysis method of Elo and Kyngäs (2007). Due to the wider nature of the topic, the limitation of new scientific articles and, my personal interest, the study was limited and has focused more on self-mutilation in the analysis part. However, as a whole, it incorporates as a whole the general behavioral characteristics and description of the self-destructive behavior or self-harm.

According to many studies, health care professionals lack an understanding of patients who show one or more kind of self-destructive behaviors. This study is significant in reviewing and analyzing new studies made in the area.

The content analysis of this study was carried out on new scientific articles that describe the nature of self-destructive behaviors and aimed at exploring models found in the new articles. In the articles it was found that self-destructive behavior, such as self-mutilation, is not an attempt to commit suicide or, but that they instead do it to attain relief, to calm down or to show their suffering and cry out for help. The need to make a clear distinction between suicidal and non suicidal self-injurious behaviors was also pointed out. Suicidal self-injurious behaviors are those self-injurious behaviors carried out to commit suicide with a clear thought to end one's own life, whereas non-suicidal behaviors are not based on a suicidal intention (Kidger, et.al, 2012, McDonald, 2006; Hinck & Hicks,2007 )

The gender involvement is also found to be different in women and men; suicidal behaviors are nearly three times higher in males in many Western and Asian countries, and males use more lethal forms of suicide, such as jumping from high places, where as women have low level of suicide intent, and they also Engage in less lethal forms of suicide, such as drug overdoses (Sun et.al, 2005, 448). The most common form of non-suicidal self-injurious act mainly seen in adolescent females is self-mutilation which can be done by to various parts of their body: ranging from arm to genitalia (Cerdorian, 2005).

Individuals who engaged in with non-suicidal self-injurious behaviors are mostly adolescents who have a dark past, abused as a child or having social, relationship, family problems or problems with their sexual orientation. In addition, substance use, mental illness, depression and Borderline personality disorder can also be other common causes for self-destructive behaviors (Cerdorian, 2005; Arkins et.al, 2012; Culhan & Taussig 2009).

Most of the analyzed articles suggested self-destructive behaviors are mostly misunderstood and individual with such problem are viewed negatively by health care professionals. Raising awareness and training health care workers is needed for the care and treatments to be successful (McHale & Felton, 2010).

For the treatment and care of self-destructive behavior different models were proposed, among those is the patient-centered model which is a model designed based on understanding of the client's need and involving the patient in the care and treatment plans.

There are number of models which follow the principles of patient-centered model and developed under it, these models are McCormack's Authentic Consciousness Model, Baker's Tidal Model, Titchen's Skilled Companionship model, Nolan's Senses framework. These models are interdisciplinary model which can be applied in different sector from elderly care to mental health care (O'Donovan, 2007).

Future studies can be done to investigate the possible prevention mechanisms, the prevalence and forms of self-destructive behaviors in men. Additional studies can be done on the prevalence and forms of self-destructive behaviors in the developing world because there is no enough information.

This study will be helpful in understanding what self-destructive behavior is and its sub groups: the suicidal and non-suicidal self-injurious behaviors, their possible causes, reasons why individuals harm themselves and models proposed to give care for individuals who suffer from these growing mental health problems.

***“Suicide is a permanent solution to a temporary problem, while self-mutilation is a temporary solution to a permanent problem”*** (Hicks & Hinck, 2008, 409).

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## Appendix 1

A sample view from the category matrix used to analyze the articles.

Category	Sub category	Analysis text
Risk factors	Intrapersonal & interpersonal factors	<p>“Factors contributing to self-harm are multifaceted. They may include feelings of hopelessness and lack of control; existing mental illness (e.g., untreated depression); impulsivity; conflict regarding sexual orientation; or academic, familial, and social problems, including divorce or unwanted pregnancy.” (Article 12)</p> <p>“The main risk factors for this are risk-taking behavior, substance misuse and interpersonal conflict, often occurring in combination in the 24 hours before the self-harm occurred.”(Article 4)</p> <p>“However, these mechanisms, which are sensitive to and respond to threats from the outside, can also respond to threats and attacks from within. For example, suggested that self-criticism can be associated with feelings of internal harassment, put-down, and defeat, whilst shame is associated with feelings of social rejection and isolation. Both internal and external criticism can have negative impacts on mood and be associated with anger at oneself and self-persecution” (Article 7)</p> <p>“Self-criticism and self-harm are often linked to early rearing experiences especially, neglectful or abusive rearing environments involving threats from dominant others and enforced subordination . Richter, Gilbert, and McEwan (2009) found that memories of feeling</p>

		<p>threatened in childhood were related to current self-criticism and depression. Those who emerge from aversive experiences with a self-critical, shame-filled, or self-disliking style are particularly prone to a range of disorders including self-harm”(Article 7)</p> <p>“Indeed, Irons et al (2006) found that self-criticism mediated the link between early childhood recall of negative rearing and depression. In a study of 5,877 adult participants from the National Co-morbidity survey, Sachs-Ericsson, Verona, Joiner, and Preacher (2006) found that self-criticism fully mediated the relationship between childhood verbal abuse and depression and anxiety, and partially mediated the relationship of self-harm to physical and sexual abuse.”(Article 7)</p>
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## Appendix 2

<b>Title</b>	<b>Author/ Year</b>	<b>Aim</b>	<b>Method</b>	<b>Result</b>
A Systematic Literature Review: Self-Mutilation among Adolescents as a Phenomenon and Help for it-What Kind of Knowledge is Lacking?? (Article 1)	Rissanen, M., Kylma, J., & Laukkanen, E. (2011)	To present current knowledge of self-mutilation among adolescents as a phenomenon and to define what kind of knowledge is lacking based on existing literature.	Inductive content analysis	Existing knowledge of self-mutilation was categorized : (1) self-mutilation as a phenomenon and (2) caring for persons who self-mutilate or self-harm
Adolescent self-harm and suicidal thoughts in the ALSPAC cohort: a self-report survey in England(Article 2)	Kidger, J., Heron, J., Lewis, G., Evans, J., & Gunnell, D. (2012)	To examines the prevalence and inter-relationships between self-harm with and without a desire to die, suicidal thoughts and suicidal plans among this age group	Cross-sectional analysis of self-reported questionnaire	Altogether 905 (18.8%) respondents had ever self-harmed. The prevalence of lifetime self-harm was higher in females (25.6%) than males (9.1%).
Assessing the reasons for deliberate self-harm in young people (Article 3)	Arkins, B., Tyrrell, M., Herlihy, E., Crowley, B., & Lynch, R. (2013)	To describe the risk factors common to individuals who attended an emergency department	Quantitative	Listed the findings of proximal risk factors under demography, interpersonal conflict, risk-taking and substance use.
Concept analysis of self-mutilation(Article 4)	Hicks, K., & Hinck, S. M. (2008)	Define and describe self-mutilation	Comprehensive literature review and Walker and Avant's concept analysis	Give definition and description of self-mutilation
Descriptions Of Self-Mutilation Among Finnish Adolescents: A Qualitative	Rissanen, M., Kylmä, J., & Laukkanen, E. (2008).	Describes self-mutilation from the perspective of adolescents.	Qualitative descriptive design	Reveals factors contributing to self-mutilation, description of self mutilation

Descriptive Inquiry. (Article 5)				from the adolescent perspective and the intentions of self-mutilation.
Patient-centred care in acute psychiatric admission units: reality or rhetoric? (Article 6)	O'Donovan, A. (2007)	To gain an understanding of psychiatric nursing practice with people who self-harm	Qualitative descriptive approach	Presented its findings on the concept of patient-centered care and how that translated in the use of Tidal model
Self-harm in a mixed clinical population: The roles of self-criticism, shame, and social rank.(Article 7)	Gilbert, P., McEwan, K., Irons, C., Bhundia, R., Christie, R., Broomhead, C., & Rockliff, H. (2010).	Explored the relationship of forms and functions of self-criticism, shame, and social rank variables to self-harm, depression, and anxiety.	Questionnaire	Self-harm was significantly associated with forms and functions of self-criticism, shame, and feelings of inferiority (low social rank)
Self-harm: what's the problem? A literature review of the factors affecting attitudes towards self-harm (Article 8)	McHale J. & Felton A. (2010)	Explore the evidence examining the attitudes of healthcare professionals in mental health and medical settings	Qualitative content analysis	There is a negative attitude towards those who self-harm due to lack of education and training.
Self-mutilation in adolescents(Article 9)	McDonald, C. (2006)	To identify and describe self-mutilation in adolescents	Qualitative content analysis	Describe classification of self-mutilation and situation management in school setting
Suicide: a literature review and its implications for nursing practice in Taiwan(Article 10)	Sun, F., Long, A., Boore, J., & Tsao, L. (2005)	Explains the risk factors, prevalence and distribution, and its implication for nursing practice	Content analysis	Risk factors, associated behavior and methods of suicide
The needs of adolescent girls who self-harm (Article 11)	Cerdorian, K. (2005)	Explore contributing factors –internal and external stressor and other incidents	Qualitative content analysis	Girl who self-harm need to be understood, listened to without being judged and

		that can contribute to self harm		suggested treatment aims
The Structure of Problem Behavior in a Sample of Maltreated Youths (Article 12)	Culhane, S. E., & Taussig, H. N. (2009)	To examine the structure of problem behavior in youth	Longitudinal study, interviewing 7 to 12 years old in a foster care	Findings indicated that a single-factor model provided a close fit for these data and compared favorably with three competing two-factor models. The single factor explained 54% of the variance in the four measures of problem behavior.
Tidal model of mental health nursing (Article 13)	Barker P. & Buchanan-Barker P. (2012)	Explained a model of care and treatment for self-destructive and other mental health problem		Detailed explanation of the Tidal model concept and its application in a multidisciplinary care
Understanding those who self-mutilate (Article 14)	Starr, D. (2004)	To gain understanding of the personal perspective of those who self-mutilate and explore the risk. Describe and define self-mutilation using different theories.		Self-mutilation is associated with childhood trauma, it is not a suicide attempt rather a desperate means to avoid suicide